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Update on WFP's response to HIV and AIDS

Executive summary

At the request of the Executive Board, the Secretariat provides regular updates on implementation of the WFP HIV and AIDS Policy,[1] which also covers WFP's response to tuberculosis. The policy is consistent with the 2030 Agenda, the strategy for 2016–2021[2] and Division of Labour[3] of the Joint United Nations Programme on HIV/AIDS and the WFP Strategic Plan (2017–2021).[4]

WFP is one of 11 Cosponsoring Organizations of the Joint United Nations Programme on HIV/AIDS. Under the joint programme's Division of Labour, WFP is responsible for ensuring that consideration of food and nutrition issues is integrated into all responses to HIV, and co-convenes work on HIV-sensitive social protection with the International Labour Organization and on addressing HIV in humanitarian contexts with the Office of the United Nations High Commissioner for Refugees. WFP addresses HIV through diverse entry points and partnerships, in line with the Sustainable Development Goals.

As a Cosponsor of the joint programme, WFP has contributed to joint responses to HIV/AIDS for many years. In 2017, it maintained its holistic and gender-responsive approach to HIV programming, leveraging its context-specific entry points and partnerships to provide food and nutrition support to vulnerable people living with HIV, including in humanitarian emergencies; support to pregnant women receiving prevention of mother-to-child transmission services; school meals and other activities for addressing the needs of children and adolescents while promoting school attendance and reducing risk-taking behaviour; support to HIV-sensitive social safety nets in several regions; technical support to governments and national partners, including work with

[1] WFP/EB.2/2010/4-A.

[2] http://www.unaids.org/sites/default/files/media_asset/20151027_UNAIDS_PCB37_15_18_EN_rev1.pdf

[3] http://www.unaids.org/sites/default/files/sub_landing/files/JC2063_DivisionOfLabour_en.pdf

[4] WFP/EB.2/2016/4-A/1/Rev.2.

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national HIV/AIDS councils; and support to supply chains to prevent stock outs of HIV treatment and prevention commodities in humanitarian settings and fragile contexts, working with partners that include the Global Fund to Fight AIDS, Tuberculosis and Malaria.

HIV and tuberculosis in 2017

1. HIV remains one of the world's most serious challenges. In 2016, 36.7 million people were living with HIV, including 2.1 million children under 15 years of age;[5] 1.8 million people were newly infected; and 1 million people died of AIDS-related causes. Since the start of the epidemic, 76.1 million people have become infected with HIV and 35 million have died from AIDS-related illnesses.[6]

2. In June 2017, 20.9 million people living with HIV had access to life-saving, anti-retroviral therapy (ART), up from 17.1 million in 2015 and 7.7 million in 2010. In 2016, about 53 percent of all people living with HIV had access to treatment: 54 percent of adults and adolescents aged 15 years and more, but just 43 percent of children aged 0–14 years. In 2016, about 76 percent of pregnant women living with HIV had access to anti-retroviral medicines to prevent the transmission of HIV to their babies.[7] While these are considerable achievements, it is also crucial to ensure that people living with HIV adhere to treatment through improved retention in care. Worldwide, AIDS is still the leading cause of death among women of reproductive age and the second leading cause among children and adolescents aged 10-19 years.[8]

3. Gender inequality and harmful gender norms continue to fuel HIV infections among young women and adolescent girls, particularly in sub-Saharan Africa. In areas with high prevalence of HIV/AIDS, young women are at unacceptably high risk of HIV infection. In eastern and southern Africa, adolescent girls and young women aged 15–24 years accounted for 26 percent of new HIV infections in 2016 despite making up just 10 percent of the population. The same population cohort accounted for 22 percent of new HIV infections in western and central Africa and for 17 percent in the Caribbean. In areas with lower prevalence, most HIV infections occur among "key populations".[9] Outside sub-Saharan Africa, key populations and their sexual partners accounted for 80 percent of new HIV infections in 2015.[10]

4. Tuberculosis (TB) is the ninth leading cause of death worldwide and the leading cause as a single infectious agent. TB is also the leading cause of death among people living with HIV, accounting for about one in three AIDS-related deaths. The risk of developing TB is estimated to be between 16 and 27 times greater in people living with HIV than among people without HIV infection. In 2016, of the 476,774 reported cases of HIV-positive people

[5] Joint United Nations Programme on HIV/AIDS (UNAIDS). 2017. *Fact sheet – Latest statistics on the status of the AIDS epidemic*. Geneva. http://www.unaids.org/en/resources/fact-sheet; World Health Organization (WHO) presumptive and definitive criteria for recognizing HIV-related clinical events among adults (15 years or older) and among children (younger than 15 years) with confirmed HIV infection. http://www.who.int/hiv/pub/guidelines/HIVstaging150307.pdf

[6] UNAIDS. 2017. *Fact sheet – Latest statistics on the status of the AIDS epidemic*. Geneva. http://www.unaids.org/en/resources/fact-sheet

[7] UNAIDS. 2017. *Fact sheet – Latest statistics on the status of the AIDS epidemic*. Geneva. http://www.unaids.org/en/resources/fact-sheet

[8] UNAIDS. 2015. *How AIDS changed everything – MDG 6: 15 years, 15 lessons of hope from the AIDS response.* Geneva. http://www.unaids.org/en/resources/documents/2015/MDG6_15years-15lessonsfromtheAIDSresponse.

[9] The key populations identified by UNAIDS as having the highest risk of contracting and transmitting HIV are female sex workers, men who have sex with men, and injecting drug users.

[10] UNAIDS. 2017. UNAIDS data 2017. Geneva. http://www.unaids.org/sites/default/files/media_asset/20170720_Data_book_2017_en.pdf

with TB, 85 percent were on ART,[11] but reported cases accounted for only 46 percent of the estimated incidence of HIV and AIDS co-infection.

5. The 2030 Agenda for Sustainable Development draws attention to the importance of accelerating progress in addressing both HIV and TB and ending the two epidemics by 2030, among other diseases. TB is strongly associated with socio-economic, gender-related[12] and structural factors. Poverty, malnutrition – undernutrition and diabetes associated with obesity are risk factors for TB – poor housing and overcrowding increase vulnerability and exposure to TB. Co-infection with HIV adds to the stigma of TB and can present major barriers to access to essential services for people living with HIV and TB.

WFP and UNAIDS: the 2030 Agenda and United Nations reform

6. WFP is one of 11 Cosponsoring Organizations of the Joint United Nations Programme on HIV/AIDS (UNAIDS). WFP ensures that food and nutrition is integrated into all HIV responses and co-convenes work on HIV-sensitive social protection with the International Labour Organization and on addressing HIV in humanitarian settings with the Office of the United Nations High Commissioner for Refugees (UNCHR). WFP addresses HIV through various entry points and partnerships that are consistent with the Sustainable Development Goals (SDGs). Improving the nutrition status and food security of people living with and affected by HIV is also a way of leveraging work towards several SDGs – on poverty alleviation, health, zero hunger, education and gender equality – and facilitating the eradication of AIDS in an era of competing priorities through more integrated, systems-based approaches that involve interventions at all levels, from the people and households directly effected by HIV to national governments.

7. The UNAIDS strategy for 2016–2021, "On the Fast-Track to End AIDS",[13] was one of the first in the United Nations system to be aligned with the SDGs and aims to advance progress towards the "three zeros" – zero new HIV infections, zero discrimination against people living with HIV, and zero AIDS-related deaths – in order to end the AIDS epidemic as a public health threat by 2030. The UNAIDS strategy is grounded in evidence and rights-based approaches, supported by the 2016 political declaration on ending AIDS of the United Nations General Assembly[14] and consistent with the 90–90–90[15] treatment targets.

8. Food and nutrition programmes play a major role in helping countries reach these ambitious targets, particularly for treatment, but also for prevention of new infections, especially among adolescent girls and young women who are at high risk of contracting HIV. As a set of indivisible goals, the SDGs give all stakeholders a mandate for integrating their efforts. The AIDS response is no exception: the epidemic cannot be ended without addressing the determinants of health and vulnerability – including food and nutrition insecurity and cross-cutting systemic gender inequalities – and the holistic and diverse needs of people at risk of and living with HIV. People living with HIV often live in fragile communities and countries and are affected by discrimination, inequality and instability. Addressing their concerns must be at the forefront of sustainable development efforts. By

[11] WHO. 2017. *Global tuberculosis report 2017*. Geneva. http://apps.who.int/iris/bitstream/10665/259366/1/9789241565516-eng.pdf?ua=1

[12] Gender-related barriers to TB services take many forms and affect both men and women. People living with TB often face stigma and discrimination, which may discourage them from seeking TB testing and treatment services. For people with HIV/TB co-infection, TB-related stigma may be exacerbated by HIV-related stigma.

[13] http://www.unaids.org/sites/default/files/media_asset/20151027_UNAIDS_PCB37_15_18_EN_rev1.pdf

[14] *United Nations General Assembly. 2016. Political Declaration on HIV and AIDS: on the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030. Resolution adopted by the General Assembly on 8 June 2016. A/Res/70/266. New York. http://www.unaids.org/sites/default/files/media_asset/2016-political-declaration-HIV-AIDS_en.pdf*

[15] By 2020, 90 percent of all people living with HIV will know their HIV status; 90 percent of all people with diagnosed HIV infection will receive sustained ART; and 90 percent of all people receiving ART will have viral suppression.

extension, lessons learned from multi-sector, multi-stakeholder AIDS responses are key to progress towards the SDGs.

9. WFP recognizes that the UNAIDS model is the best approach to accelerating progress towards the SDGs in accordance with the United Nations reform. WFP is fully committed to putting the 2030 Agenda and the United Nations reform into practice and to improving linkages between humanitarian and development approaches in order not only to reach the most vulnerable people but also to support people in building stronger and more resilient communities.

Funding outlook for 2018

10. As a Cosponsor, WFP receives funding from UNAIDS and is accountable under the United Budget, Results and Accountability Framework, which brings together the responses to AIDS of all United Nations agencies, promoting coherence and coordination in planning and implementation and channelling catalytic funding for agencies' HIV responses. Funding from UNAIDS is for use in increasing the capacity and resources for HIV responses at the country, regional and global levels as part of multi-sector initiatives.

11. UNAIDS faced a severe funding shortfall for its biennial budget in 2016–2017. Of an approved budget of USD 242 million, only USD 168 million was raised in 2016, resulting in a 50 percent cut in funding to Cosponsors. In response to the shortfall the UNAIDS Programme Coordinating Board called for the creation of a Global Review Panel[16] (GRP) to review the operating model of UNAIDS. WFP served as a representative of Cosponsors in the GRP.

12. Informed by the findings of the GRP, an action plan[17] was developed in 2017. The plan recommends following a dynamic process for resource allocation in order to ensure that funds are directed to where they are most needed. The new model for resource allocations includes a total of USD 22 million per year for the cosponsors to fund joint work at the country level. These allocations take the form of country envelopes for leveraging joint actions in 33 "fast-track" countries[18] and supporting the populations in greatest need in other countries; they are in addition to the yearly minimum core allocation of USD 2 million per Cosponsor. This revised resource allocation model was approved at the 40th meeting of the Programme Coordinating Board along with the UNAIDS budget for 2018–2019.

13. WFP country offices in all regions took part in the UNAIDS country envelope process, which resulted in a total allocation of USD 1,039,300 for WFP country offices in 2018. WFP's value added was particularly recognized in west and central Africa and in the area of social protection. With reduced core funding from UNAIDS, WFP continues to prioritize the most vulnerable countries and fast-track countries for its activities. It will continue to mainstream consideration of HIV/AIDS issues in its regular programming in order to ensure maximum impact.

[16] UNAIDS. 2017. *Final report — Global Review Panel on the future of the UNAIDS Joint Programme*. Geneva. http://www.unaids.org/en/resources/documents/2017/final-report_grp

[17] UNAIDS. 2017. *Fast-forward: refining the operating model of the UNAIDS Joint Programme for Agenda 2030*. Geneva. http://www.unaids.org/en/resources/documents/2017/fast-forward-refining-operating-model-unaids-2030

[18] The UNAIDS fast-track countries are Angola, Botswana, Brazil, Cameroon, Chad, China, Côte d'Ivoire, the Democratic Republic of the Congo, Eswatini, Ethiopia, Ghana, Haiti, India, Indonesia, the Islamic Republic of Iran, Jamaica, Kenya, Lesotho, Malawi, Mali, Mozambique, Myanmar, Namibia, Nigeria, Pakistan, the Russian Federation, South Africa, South Sudan, Uganda, Ukraine, the United Republic of Tanzania, the United States of America, Viet Nam, Zambia and Zimbabwe.

WFP's contribution to the UNAIDS strategy for 2016–2021

Strategic result area 1: Children and adults living with HIV have access to testing, know their status and are immediately offered and sustained on affordable quality treatment (outputs 1.1, 1.2, 1.3, 1.5 and 1.6)[19]

14. WFP's work on addressing HIV is gender-responsive and focuses on linking food and health systems through the provision of food assistance for better health outcomes, such as nutritional recovery for people living with HIV and/or TB, retention in care programmes, and successful completion of treatment. WFP contributes through advocacy and communications; partnerships; the inclusion of food security and nutrition in comprehensive national plans for addressing HIV/AIDS in order to meet the needs of vulnerable people living with HIV; and technical support, capacity building and assistance for implementation. WFP provides direct support, including food and cash-based transfers, to individuals and households in order to facilitate improved access and adherence to treatment.

15. In 2017, WFP provided technical assistance to governments with a view to integrating food and nutrition services into HIV responses through the development of national guidelines on nutrition assessment, counselling and support for adolescents and adults living with HIV, including in Eswatini, Kenya, Lesotho, Rwanda and Somalia.

16. In 2016–2017, WFP started to collaborate with the All-Ukrainian Network of People Living with HIV on launching a food assistance intervention using conditional e-vouchers and targeting household members affected by HIV. This resulted in improved food security status for two thirds of beneficiaries while 34 percent adhered to treatment for longer. WFP also continues to provide food and/or cash-based transfers to vulnerable people, including people living with HIV and/or TB in emergency and refugee settings in the Central African Republic, Haiti, Myanmar, South Sudan, Uganda, the Horn of Africa, the Lake Chad basin and countries affected by El Niño.

17. In many humanitarian, refugee and other food-insecure settings, including in Cameroon, Kenya, Lesotho, Rwanda, Somalia, South Sudan, Uganda and Zimbabwe, WFP provided food and nutrition support to malnourished or food-insecure people on ART.

18. Substantial advocacy efforts at the global and regional levels in 2016 resulted in a grant from the United States President's Emergency Plan for AIDS Relief (PEPFAR) of more than USD 25 million for addressing the impacts of El Niño-related food insecurity in five countries – Eswatini, Lesotho, Malawi, Mozambique and Zimbabwe. The work, which continued in 2017, focuses on assessment and treatment of severe and moderate acute malnutrition in people living with HIV through existing programmes providing nutrition assessment, counselling and support for adolescents and adults living with HIV; activities include nutrition screening and referrals in communities, and assessment, counselling and treatment at clinics. Through the PEPFAR grant, in 2016 and 2017 WFP managed supply chains for specialized foods and supported 335,594 malnourished and food-insecure people affected by HIV, including orphans and other vulnerable children and clients of prevention of mother-to-child transmission (PMTCT) programmes in five UNAIDS fast-track countries.

19. During humanitarian emergencies, forced displacement, food insecurity, poverty, sexual violence, breakdown of the rule of law and the collapse of health systems may lead to increased vulnerability to HIV infection or interruption of treatment. Given the scale and scope of humanitarian emergencies, the number of people vulnerable to HIV in these

[19] 1.1 HIV testing and counselling; 1.2 HIV treatment cascade (a continuum of services from HIV testing to retention on ART); 1.3 Children and adolescents; 1.5 Humanitarian emergencies; and 1.6 Access to medicines and commodities.

situations is estimated to have increased. UNHCR and WFP lead the HIV response in humanitarian emergencies.

20. In the last two years, the importance of addressing HIV in humanitarian settings has received more political support than ever before, as highlighted in the UNAIDS strategy for 2016–2021, the two reports to the Programme Coordinating Board presented by the UNAIDS Executive Director in 2017, and the engagement in emergency responses of PEPFAR and the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund).

Strategic result area 2: New HIV infections among children are eliminated and the health and well-being of the children's mothers are sustained (output 2.1)[20]

21. Demand-side barriers to access and adherence to PMTCT services[21] include food insecurity. Comprehensive services with integrated food assistance enable more women to start and adhere to PMTCT programmes.

22. WFP works with governments to support PMTCT programmes and provide mother-and-child health and nutrition services to vulnerable pregnant women. WFP programmes in many contexts target pregnant and lactating women, PMTCT clients and children, and can have impacts on adherence to PMTCT and on health outcomes for newborn babies. In South Sudan, WFP provided nutrition support to 7,736 pregnant and lactating women and girls through its PMTCT programme, and an additional 224,799 pregnant and lactating women and girls were treated for acute malnutrition through the targeted supplementary feeding programme. Development of national guidelines on maternal, infant and young child nutrition has created a platform for improving the quality of mother-and-child nutrition services, especially for women and children affected by HIV.

23. In 2014, WFP and the Global Fund signed a memorandum of understanding (MOU) for a logistics partnership that aims to improve access to commodities for the HIV response, especially during emergencies, through WFP's supply chain networks in the deep field. A core component of the MOU tasks WFP with building the capacity of Global Fund recipients to strengthen distribution systems. In 2016 and 2017, WFP facilitated the delivery of air and ocean cargoes to Burundi and Yemen to prevent supply gaps in HIV treatment programmes.

Strategic result area 3: Young people, especially young women and adolescent girls, have access to combined prevention services and are empowered to protect themselves from HIV (output 3.2)[22]

24. WFP contributes to strengthening national capacities to meet the goals for HIV prevention among young people and adolescents through its HIV-sensitive school meal programmes and its country-level partnerships with the United Nations Population Fund (UNFPA) and the United Nations Children's Fund (UNICEF). WFP's school meals benefit more than 17 million schoolchildren annually. In Malawi, more than 990,000 children were reached in 13 districts. By staying in school longer, many of these young people are less exposed to high-risk behaviour that can lead to acquiring HIV.

25. In Zambia, in partnership with the Scaling Up Nutrition (SUN) Civil Society Network, WFP investigated the barriers that hinder adolescent girls' access to HIV and nutrition services. Gaps identified included low utilization of HIV testing and counselling services, very low condom use, very limited youth-friendly services and inadequate behaviour change programmes for addressing both HIV and nutrition issues among adolescents. In 2017, WFP

[20] 2.1 PMTCT.

[21] O'Hlarlaithe, M., Grede, N., de Pee, S. and Bloem, M. 2014. Economic and social factors are some of the most common barriers preventing women from accessing maternal and newborn child health and PMTCT services: A literature review. *AIDS and Behaviour*, 18 (Suppl. 5): S516–S530.

[22] 3.2 Young people and adolescents.

supported the establishment of technical working groups that consider issues that are specific to adolescents in two districts to enhance support to and inclusion of adolescent girls in nutrition and HIV programming.

Strategic result area 7: AIDS response is fully funded, and efficiently implemented based on reliable strategic information (output 7.2)[23]

26. WFP's vulnerability assessments inform HIV responses in several countries. In Burundi, for example, during development of the national strategic plan for fighting HIV/AIDS in 2017–2021, WFP assessed the nutrition status and vulnerability of people living with HIV.

27. In line with WFP's ongoing digital transformation and new Nutrition Policy,[24] WFP is expanding its digital beneficiary system and is developing an application for the electronic registration, tracking and management of beneficiaries of community-based management of acute malnutrition programmes. The application, known as "SCOPE conditional on-demand assistance", is based on WFP's corporate digital beneficiary and transfer management platform, SCOPE, and will provide the information needed to ensure that nutrition and HIV programmes are gender-transformative and empowering. In 2017, WFP prioritized people living with HIV for registration at food distribution centres, and this is currently under way in Somalia.

28. WFP works with national governments and other partners on improving the sustainability, gender-responsiveness and effectiveness of its HIV programmes, particularly through its technical support and capacity building programmes. In Lesotho, WFP provided technical support to the Ministry of Health to strengthen a technical working group on nutrition that aims to integrate consideration of HIV issues into nutrition programmes. Through this support, in collaboration with the Elizabeth Glaser Paediatric AIDS Foundation, WFP assisted the ministry in quantifying data on the clients of health programmes, including people living with HIV, in need of nutrition assistance.

29. In Burundi, WFP and other United Nations agencies worked in partnership to organize the 2017 demographic and health survey, which found that health and nutrition outcomes had either improved or remained the same compared with the 2010 survey. UNICEF and WFP agreed to organize a nutrition assessment using the specific, measurable, attainable, relevant and time-bound (SMART) methodology based on a consensual approach in order to update findings.

Strategic result area 8: People-centred HIV and health services are integrated into stronger health systems (outputs 8.1 and 8.2)[25]

30. Social protection programmes are increasingly recognized as facilitators of improved HIV prevention and treatment outcomes. For example, a study of 1,059 adolescents aged 10–19 years living with HIV in South Africa showed that three elements of social protection – food and nutrition support through the provision of two meals a day, attendance in an HIV support group, and a high level of supervision from parents and caregivers – were associated with improved treatment adherence.[26]

31. WFP contributes to the empowerment of people living with HIV through its HIV-sensitive social protection programmes, including by supporting governments in designing, putting into operation and evaluating cost-effective safety net and social protection mechanisms for

[23] 7.2 Technological innovations.

[24] WFP/EB.1/2017/4-C.

[25] 8.1 Integration; and 8.2 Social protection.

[26] Cluver, L.D., Toska, E., Orkin, F.M., Meinck, F., Hodes, R., Yakubovich, A.R. and Sherr, L. 2016. Achieving equity in HIV treatment outcomes: can social protection improve adolescent ART adherence in South Africa? *AIDS Care*, 28 (Suppl. 2): 73–82.

people living with HIV and other vulnerable populations, including in fragile and challenging conditions.

The year in numbers

32. In 2017, WFP assisted 354,579 TB patients, people living with HIV[27] and their household members in 24 countries through HIV-specific programmes (Table 1). In addition, many more vulnerable people living with and affected by HIV were assisted through WFP's general food assistance, but they are not included in this report, which focuses only on HIV-specific programming.

TABLE 1: BENEFICIARIES OF HIV- AND TB-SPECIFIC PROGRAMMES, 2017*	
UNAIDS fast-track countries	266 606
Other countries	87 973
Total	**354 579**

* Based on preliminary results of 2017 standard project reports.

Partnerships

33. The provision of supply chain services to health actors – including the Bill & Melinda Gates Foundation – is one example of WFP's contribution to SDG 17 and leverages new and innovative approaches for tackling chronic constraints in supply chains. Health actors have acknowledged WFP's supply chain expertise and are increasingly looking to WFP to support them in reaching the most vulnerable populations in the most fragile and hard to reach settings.

34. WFP works with Global Fund partners – including the United Nations Development Programme in Zimbabwe and the Partnership for Supply Chain Management in Burundi – in programme implementation and supply chains in order to prevent supply gaps in HIV treatment and prevention programmes. These partnerships are ideal examples of working towards SDG 17 and their results demonstrate how WFP's supply chain can be leveraged for HIV-related impacts, including in Burundi and Yemen (see paragraph 23).

35. In Myanmar, WFP supports the clinics provided by the national AIDS programme of the Ministry of Health and Sports by providing food and nutrition assistance to people living with HIV, including cross-border migrants returning home. In 2017, WFP supported an extended post-distribution monitoring exercise to assess the effectiveness and impact of food and nutrition assistance for people living with HIV. The monitoring exercise showed that nutrition counselling and food provision resulted in ART adherence of 99 percent, underscoring the importance of food and nutrition support in improving treatment adherence outcomes.

36. WFP and UNHCR co-convene the inter-agency task team on HIV in emergencies. In 2016 and 2017, the task team provided expertise and technical guidance, advocated for funding and gender-responsive policy outcomes, acted as a coordination mechanism for joint initiatives, and facilitated country-level partnerships. Joint initiatives included updating the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings and the SPHERE[28] guidance on universal minimum standards for humanitarian response; convening a working group in El Niño; developing advocacy briefs on the HIV response in South Sudan and on El Niño-related emergencies; and engaging with the cluster system to integrate HIV issues

[27] 193,462 women and girls, and 161,117 men and boys.

[28] The Sphere Handbook is one of the most widely known and internationally recognized sets of common principles and universal minimum standards for the delivery of quality humanitarian response. Because it is not owned by any one organization, the Sphere Handbook enjoys broad acceptance by the humanitarian sector.

into emergency responses. These initiatives are good examples of working on the humanitarian-development nexus.

Outlook in 2018

37. WFP will continue to contribute to ending AIDS by linking food and health systems to HIV/AIDS responses in accordance with the new Nutrition Policy (2017–2021) and by leveraging several entry points, including food and nutrition, social protection and emergency response. WFP will continue to adapt its work and delivery platforms in order to remain relevant, equitable and effective in building the capacities of government counterparts. WFP will also continue to pursue gender-transformative approaches in all HIV and TB interventions, and to provide general food assistance or cash-based transfers to vulnerable people – including people living with HIV and/or TB – in humanitarian settings in the Central African Republic, Haiti, Myanmar, South Sudan, the Horn of Africa, the Lake Chad basin and other affected countries.

38. In the current funding environment, the focus will increasingly be on UNAIDS fast-track and other countries with existing programmes for addressing the diverse needs of emergency-affected populations. The Nutrition Division will work with regional bureaux, country offices and other units to ensure that HIV programming is properly incorporated into country strategic plans.

39. WFP will promote the active participation and engagement of all vulnerable groups and segments of the population – including people living with HIV and/or TB – in programme decision-making, from the targeting of the most vulnerable to the selection of the most appropriate food assistance modalities for the specific context.

40. The global AIDS response has inspired innovations in global health, sustainable development and coordination in the United Nations development system. Joint United Nations support to the response and the Global Health Partnership H6[29] provide opportunities for accelerating United Nations reform and progressing towards the SDGs for health, well-being and gender equality. WFP is committed to supporting the H6 partners in reaching the most vulnerable people and will continue to advocate for funding to address the diverse needs of food-insecure people living with HIV in the Horn of Africa.

[29] The H6 partners are UNAIDS, UNFPA, UNICEF, UN-Women, the World Health Organization and the World Bank.

Acronyms used in the document

ART	anti-retroviral therapy
GRP	Global Review Panel
MOU	memorandum of understanding
PEPFAR	United States President's Emergency Plan for AIDS Relief
PMTCT	prevention of mother-to-child transmission
SDG	Sustainable Development Goal
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNHCR	Office of the United Nations High Commissioner for Refugees
WHO	World Health Organization